Hospital Sisters HEALTH SYSTEM

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SYSTEM: Hospital Sisters Health System	**MANUAL(S): Executive Manual**
TITLE: Residents and Interns - Patient Care Activities Policy	**ORIGINATING DEPARTMENT: Quality and Physician Relations**
EFFECTIVE DATE: February 3, 2020	**REVISION DATE(S): 11/8/22; 11/2021**
SUPERSEDES: New	

***** As required by CMS Regulation §482.12 A-0043 Conditions of Participation: Governing Body, the following hospitals and entities are included as HSHS entities: **ILLINOIS**: (1) HSHS St. John's Hospital – Springfield (2) HSHS St. Mary's Hospital – Decatur, (3) HSHS St. Francis Hospital – Litchfield, (4) HSHS Good Shepherd Hospital – Shelbyville, (5) HSHS St. Anthony's Memorial Hospital – Effingham, (6) HSHS St. Joseph's Hospital – Highland, (7) HSHS St. Joseph's Hospital – Breese, (8) HSHS St. Elizabeth's Hospital – O'Fallon, (9) HSHS Holy Family Hospital – Greenville, (10) HSHS Physician Enterprise (HSHS Medical Group – Illinois, Prairie Cardiovascular Consultants). **WISCONSIN**: (1) HSHS St. Vincent Hospital – Green Bay, (2) HSHS St. Mary's Hospital Medical Center – Green Bay, (3) HSHS St. Clare Memorial Hospital – Oconto Falls, (4) HSHS St. Nicholas Hospital - Sheboygan, (5) HSHS Sacred Heart Hospital – Eau Claire, (6) HSHS St. Joseph's Hospital – Chippewa Falls, (7) HME Home Medical, (8) Libertas Treatment Center – Green Bay and Marinette, (9) HSHS Physician Enterprise (HSHS Medical Group – Wisconsin).

I. POLICY:

Residents and Interns are physicians in a training capacity who, within an approved medical training program and under the supervision of identifiable providers that are appropriately licensed and credentialed Medical Staff Members, participate in patient care activities in the clinic, and outpatient and inpatient hospital setting. Residents and Interns who work with Attending Medical Staff Members and Sponsoring Medical Staff Members are required to adhere to the provisions of this policy.

In combination with HSHS Policy (RCM-RCC-01): *Residents & Interns – Documentation & Professional Billing Requirements,* this policy addresses approved patient care activities and documentation requirements.

II. PURPOSE:

To provide guidelines for the appropriate supervision and scope of patient care activities involving Residents and Interns.

1. To define who may participate.
2. To define extent of participation.
3. To define supervision or responsibility for the participants.
4. To safeguard patient care and enhance graduate medical education.
5. To comply with regulatory standards.

III. SCOPE:

This policy is applicable to all HSHS hospitals*, Physician Organizations, and operating entities including their employees, agents and medical staff.

IV. DEFINITIONS:

1. "Internship/1st year Resident" ("Intern") (Post Graduate Year One (PGY-1)) refers to a person in the first year of a residency training program. Interns may have a Residential Educational License (REL) (Wisconsin) or a Temporary License (Illinois) (collectively, "Temporary License") to practice medicine.

2. "Resident" (Post Graduate Years Two through Five (PGY-2-5)) refers to a person in the second or subsequent year of a residency training program, who is working towards or has obtained a Permanent License to practice medicine.

3. "Temporary License" refers to a license used by all PGY1 and some PGY2 Residents, within the residency training program, until the Resident is granted a Permanent License.

   The holder of a Temporary License may, under the direction of a person licensed to practice medicine and surgery in the state, perform services requisite to the postgraduate training program in which the licensee is serving. Acting under such direction, the Temporary Licensee shall also have the right – pursuant to state law and Centers for Medicare and Medicaid (CMS) requirements, acting only within scope of his or her employment and training program approval, and Hospital policy – to prescribe drugs and controlled substances, and to sign any certificates, reports or other papers for the use of public authorities, which are required of, or permitted to persons licensed to practice medicine and surgery. The Temporary Licensee shall confine their training and entire practice, to the postgraduate training program with which they are participating.

4. "Permanent License" refers to the (full) medical license received after training in the United States. Residents must have their Temporary License after completion of 24 months post graduate training, or not less than twelve (12) months per State requirements, and passage of all required examinations before applying for their Permanent License.

5. "Fellow" refers to a person who has completed medical school and residency and is undergoing additional training in a medical subspecialty. Fellows are covered under Hospital Bylaws and/or Medical Staff Rules and Regulations, Credentials Committee Policy, etc.

6. "Provider Students" refers to:

   A. A medical student enrolled in medical school to become a DO or MD. This is not an approved GME program. A medical student is never considered to be a Resident or Intern.

   B. An Advanced Practice Practitioner (APP) student enrolled in school to become a PA, NP, CNMW, CRNA or APRN. (May also be referred to as a Non-Provider Practitioner (NPP)).

   C. A dental student enrolled in dental school to become a DDS or DMD.

   D. See HSHS Policy: *Provider Students – Patient Care Activities (D-38)*.

7. "Residency Program Director" refers to the individual that develops, oversees and improves the residency or fellowship program, according to a set of responsibilities articulated in the ACGME Common Program Requirements.

8. "Sponsoring Medical Staff Member" (Sponsoring MSM) refers to a physician (other than a Resident or Intern) who assumes educational and supervisory responsibility for a Resident or Intern, while rotating at the Hospital, and involves the Resident or Intern in the care of the Sponsoring MSM's patients.

9. "Attending Medical Staff Member" (Attending MSM or Teaching Physician), refers to a licensed practitioner who holds admitting and/or attending provider privileges at the hospital, consistent with the requirements delineated in the Hospital Medical Staff Bylaws, and involves the Resident or Intern in the care of his or her patients. The Attending MSM may also be the Sponsoring MSM.

   A. For inpatients – the Attending MSM is the physician with primary responsibility for a patient's care during the admission and who orders (or authenticates the order) for services. This assignment can be changed, if care is being transferred to another physician.

   B. For outpatients – the Attending MSM is the physician who orders (or authenticates the order) for the service.

   C. Occasionally, education is provided by a licensed, independent practitioner from a discipline other than medicine (i.e., midwives, dentistry/oral surgery, etc.). Educational standards and expectations are the same as for Attending MSM.

Throughout this policy, "MSM" will collectively refer to both Attending and Sponsoring MSMs, unless specifically referenced. Note that CMS refers to MSM in the role of the Attending, as the "Teaching Physician."

10. "Supervision" refers to the requirement for each Resident and Intern to be supervised by a physician who holds clinical privileges that reflect the patient care responsibilities assigned to Residents and Interns. If the supervising physician is unavailable, supervision must be turned over to the covering physician.

    A. Per the Accreditation Council for Graduate Medical Education (ACGME), each patient must have an identifiable, appropriately credentialed and privileged MSM who is ultimately responsible for the care of the patient. The supervising physician may be a more advanced Resident or Fellow, depending on skill level.

    B. Similarly, CMS Medicare PATH Rules provide that Attending MSM's (referred to as Teaching Physicians by CMS) may supervise Residents or Interns and bill for the professional services performed by the MSM, which includes Resident or Intern activity. *Refer to HSHS Policy (RCM-RCC-01): Residents & Interns – Documentation & Professional Billing Requirements.*

    C. ACGME and CMS Teaching Physician supervision levels are defined differently:

ACGME Supervision Levels
Direct Supervision: (a) The supervising physician is physically present with the Resident during key portions of the patient interaction. PGY-1 Residents must initially be supervised only as described in (a)); OR (b) the supervising physician concurrently monitors the patient care through appropriate telecommunication technology.
Indirect Supervision -*Immediately Available*: Supervising physician *is not providing physical or concurrent visual or audio supervision but* is immediately available to provide appropriate direct supervision.
Oversight: The supervising physician is available to provide review of procedures/encounters with feedback after care is delivered. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each Resident must be assigned by the Residency Program Director. Sponsoring MSM's functioning as supervising physicians must delegate portions of care to Residents based on individual skill and patient needs.
CMS Teaching Physician Supervision
Personal Supervision: Supervising physician is present in the room with the patient.
Direct Supervision: Supervising physician is immediately available (on-campus) to furnish assistance and direction throughout the performance of the procedure.
General Supervision: Furnished under the overall direction and control of the supervising physician, but his/her physical presence is not required during the procedure.

V. GUIDELINES/PROCEDURES:

1. The following guidelines apply to Residents and Interns working within their training program:

    A. Residents and Interns function in accordance with responsibilities and expectations described in their respective Residency's curriculum, in conjunction with their sponsoring ACGME institution and program specific requirements. The curriculum is updated based upon feedback from attendings, resident physicians, and accreditation requirements.

    B. Per ACGME, the clinical responsibilities for each Resident or Intern must be based on PGY-level, patient safety, Resident/Intern education, available support services, and severity and complexity of the patient's illness/condition.

    C. The MSM who is supervising the Resident must hold current clinical privileges that reflect the patient care responsibilities assigned to the Resident.

D. All aspects of patient care are ultimately the responsibility of the MSM, regardless of whether certain tasks have been delegated to the Resident.

E. The MSM and/or any patient has the right to prohibit Residents from participating in the care of patients. When allowing Residents to care for their patients, MSMs do not relinquish their rights and responsibilities, or diminish the standard of availability required for MSMs.

F. Generally, in order for a service to be payable under the Medicare Physician Fee Schedule, the MSM must be present during all critical or key portions of the service or procedure, and immediately available to furnish care during the entire encounter. *Refer to HSHS Policy (RCM-RCC-01): Residents & Interns – Documentation & Professional Billing Requirements.*

2. Residents Working Outside of their Training Program

Moonlighting and Fellows: Residents functioning as independent practitioners outside their residency program (i.e., "moonlighting") and Fellows shall refer to the Hospital's Medical Staff Bylaws, Rules and Regulations. Those who "moonlight" shall also refer to their academic institution's policy on residency moonlighting.

VI. SCOPE OF ACTIVITIES

1. Approved Patient Care Activities – **Permanent License**

A. Residents with a Permanent License may perform procedures, provided:

1. They have the permission of the MSM, and

2. The procedure is related to the educational objectives specified for the Resident in the applicable Affiliation Agreement or any related documents.

B. Residents with a Permanent License may be permitted, at the discretion of the MSM, to provide services, at a minimum, under their Direct or Indirect Supervision based on the definitions by ACGME above, and the Resident's achieved competencies. The MSM must be immediately available.

2. Approved Patient Care Activities – **Temporary License**

A. Patient services provided by Residents with a Temporary License, must be initially supervised under Direct Supervision, where the supervising MSM is physically present during the key portions of the patient interaction per ACGME.

B. Once a Temporary Licensee has established an acceptable level of competence, the Resident Review Committee may describe the conditions which the Resident or Intern progresses to be supervised Indirectly by the MSM, per ACGME.

C. PGY-1 Interns are not allowed to moonlight independently per ACGME, as they do not meet credentialing eligibility criteria for Medical Staff membership.

3. Patient Care Orders

A. Residents and Interns may provide written, telephone, or verbal orders without a required co-signature with the following *exceptions, which will require co-signature of the MSM*:

1. Hospital Admission orders

2. Controlled (Schedule II-V) medication prescription orders at discharge. Residents and Interns may only prescribe controlled medications under the Institutional (Hospital) DEA number and pursuant to Hospital Bylaws, Rules and Regulations, and policy.

B. Orders must be signed, dated, and timed by Residents and Interns and/or the MSM within required timeframe pursuant to Hospital policy.

1. Any Resident or Intern e-prescribed orders for post-discharge, controlled substances must be countersigned by the MSM prior to the patient's actual discharge from the hospital, as these e-prescriptions will NOT be viewable by the outpatient pharmacy until the MSM countersigns them.

2. If the cosigning MSM alters the electronic prescription order, the MSM's DEA number will be attached to the order and they will become the ordering provider.

C. It is recommended that Residents enroll in the necessary Federal and State programs, (i.e., DEA and Medicare Provider Enrollment Chain Ownership System (PECOS)), as they become eligible.

4. Medical Record Documentation (as defined in *Hospital Policy, Medical Staff Bylaws and/or Medical Staff Rules and Regulations)*

A. It is the responsibility of the MSM to assess the patient daily, to countersign or augment the Resident or Intern documentation, or to create their own note. Upon medical review, the combined entries in the medical record by the MSM and the Resident constitute the documentation for the service and, together, must support the medical necessity of the service.

1. The MSM or Resident/Intern shall document the MSM's physical presence during key or critical portions of the service, and their participation in the management of the patient.

a. When a Resident/Intern performs a visit without MSM presence, the MSM must repeat the key portions of the visit and create their own documentation in order for the service to be paid.

b. *Refer to HSHS Policy (RCM-RCC-01): Residents & Interns – Documentation & Professional Billing Requirements.*

B. Documentation entered by a Resident or Intern must be signed/dated/timed and clearly identified as the Resident's or Intern's documentation.

C. Timelines for completion of medical record documentation are identified in the Hospital Policy, Medical Staff Bylaws and/or Medical Staff Rules and Regulations.

D. Documentation is completed using the same templates available to the MSM.

E. At a minimum, records will be "signed with co-signature" by the Resident or Intern and remain in an editable status until the MSM *countersigns with the attestation* appropriate for the service, within the timeframe required per policy.

1. MSM Acceptable Attestations:

a. Example 1

"I was present during all critical and key portions of the procedure(s) and immediately available to furnish services throughout the entire duration of the service. I participated in the management of this patient and I agree with the Resident's note as documented."

b. Example 2

"I was present with the Resident during the history and exam, and I discussed the case with the Resident. I agree with the findings and plan as documented in the Resident's note."

c. Example 3 – Primary Care Exception Only

"I supervised the service and have ensured the care provided by the Resident was reasonable and necessary. I have reviewed the medical history, exam findings, diagnosis and treatment plan – all of which I agree."

i. If granted specific approval by Medicare, the Primary Care Exception (PCE) within an approved GME Program applies to limited situations when the Resident is the primary caregiver and the Teaching Physician sees the patient only in a consultative role. There are specific requirements under this exception.

ii. Refer to *HSHS Policy (RCM-RCC-01): Residents & Interns: Documentation & Professional Billing Requirements.*

F. Use of copy and paste technology can improve accuracy, thoroughness, and efficiency of EMR documentation, only if used appropriately. Refer to *Use of Copy and Paste Technology in EMR* HSHS policy (MR-01).

VIII. DISTRIBUTION:

Affiliated Residency Program Medical Directors
Medical Staff Members

IX. REFERENCES:

ACGME *Common Program Requirements (Residency)*, February 3, 2020
Joint Commission Standards MS.04.01.01
CMS MLN Booklet, *Guidelines for Teaching Physicians, Interns, & Residents*, ICN 006347, March 2018
Medicare Claims Processing Manual, 100-04, Chapter 12, Section 100 – *Teaching Physicians*
Medicare Benefit Policy Manual, 100-02, Chapter 15, Section 30.2 – *Teaching Physician Services* and Section 30.3 – *Interns and Residents*.
NGS Medicare, Policy Education Topics, *Teaching Environment E/M Services*, July 2018
Illinois Administrative Code, Title 77, Chapter XV, Part 3100 *Illinois Controlled Substances Act*, Section 1300.80

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